


The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Prairie States Enterprises at 800-615-7020. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 800-615-7020 for a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers : \$6,350 Individual / \$12,700 Family; for out-of-network providers \$12,700 Individual / \$25,400 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care is covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For network providers : \$6,350 Individual / \$12,700 Family; for out-of-network providers \$12,700 Individual / \$25,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. HPS: www.hps.md or call 1-888-477-7968 for a list of network providers; Out of Area MultiPlan: www.multiplan.com or call 1-800-279-9776.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	This plan will allow you to see a specialist of your choice without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance after deductible	0% coinsurance after deductible	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Specialist visit	0% coinsurance after deductible	0% coinsurance after deductible	
	Preventive care/screening/immunization	0% deductible waived	0% coinsurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required for imaging.
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	0% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-800-334-8134	Generic drugs (Tier 1)	0% coinsurance after deductible	Not Covered	Retail Pharmacy - maximum 30 day supply; Mail Order maximum 90 day supply.
	Preferred brand drugs (Tier 2)	0% coinsurance after deductible	Not Covered	
	Non-preferred brand drugs (Tier 3)	0% coinsurance after deductible	Not Covered	
	Specialty drugs (Tier 4)	0% coinsurance after deductible	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required for outpatient surgical services.
	Physician/surgeon fees	0% coinsurance after deductible	0% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	Network Benefits Apply	
	Emergency medical transportation	0% coinsurance after deductible	Network Benefits Apply	
	Urgent care	0% coinsurance after deductible	0% coinsurance after deductible	

* For more information about limitations and exceptions, see the [plan](#) or policy document by calling your Human Resources Dept or Prairie States.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required for inpatient hospitalizations.
	Physician/surgeon fees	0% coinsurance after deductible	0% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required for inpatient hospitalizations.
	Inpatient services	0% coinsurance after deductible	0% coinsurance after deductible	
If you are pregnant	Office visits	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required for inpatient hospitalizations.
	Childbirth/delivery professional services	0% coinsurance after deductible	0% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	0% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	0% coinsurance after deductible	Limited to 40 visits per year. Preauthorization is required.
	Rehabilitation services	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required
	Habilitation services	0% coinsurance after deductible	0% coinsurance after deductible	
	Skilled nursing care	0% coinsurance after deductible	0% coinsurance after deductible	Limited to 30 days per year. Preauthorization is required.
	Durable medical equipment	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required for all rentals and any purchases over \$500.
	Hospice services	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|-------------------------|--|--|
| • Acupuncture | • Hearing Aids | • Routine eye care (Adult) |
| • Bariatric Surgery | • Long-Term Care | • Routine foot care |
| • Cosmetic Surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs (unless covered by the ACA) |
| • Dental Care | • Private-Duty Nursing | |
| • Infertility Treatment | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: : the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-615-7020.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-615-7020.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-615-7020.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-615-7020.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$6350
■ Specialist copayment	N/A
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,350
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,410

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$6350
■ Specialist copayment	N/A
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$5,400
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,420

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$6350
■ Specialist copayment	N/A
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is-	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.